DEATH INVESTIGATION REPORT Case Number_____
Investigator's Form (IDIRF)12.94

Decedent's Name_____
FIRST MIDDLE LAST

Medical Examiner's Office

Decedent: Age_____Race_____Sex_____Ethnicity_____DOB_____SS#_____

Home Address_____
Street # Street Name City County State Zip

Police Complaint Number_____Police Department_____

ACTION	DATE	TIME	REMARKS	BY WHOM (PERSON OR AGENCY)
ME notified			Intake by:	
Scene visit			Photos? —Yes —No	
NOK notified			Person:	

DESCRIPTION OF CIRCUMSTANCES: (Include **how** the incident is thought to have occurred, decedent's **activity** at the time of the incident, the **type of place**, and the **sequence of events**). **If extra pages are used, indicate number here:**

_____

_____

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Death Place >>>	___On Scene(S) ___Enroute/DOA(D) ___Emerg Rm(E) ___In Surgery(O) ___Inpatient(I)

ACTION	DATE	TIME	ADDRESS: STREET NUMBER/CITY/COUNTY/STATE/ZIP	
Injury/event				
Actual death				
Pronounced				
At hospital			Hospital:	Taken by:
Pronounced by	Person:			License#:

IF FOUND	DATE	TIME	WHERE (NAME OF PLACE OR STREET ADDRESS)	BY WHOM	
When					
Last known OK					
			Condition when found: —Not Conscious(N)	—Dead(D)	—In distress(I)
			How last known alive or okay: —Seen(S)	—Heard(H)	—Other(O)

Concerning the onset of fatal events >>>>>	___Witness present (W) **OR** ___Unwitnessed/no witnesses known (U) ___At own residence (H) **OR** ___Away from home/ not at own residence (A) ___Indoors (I) **OR** ___Out-of-doors (O) ___In vehicle (V) **OR** ___Not in vehicle (N) ___While on the job (J) **OR** ___Not while on job (S)
Place of onset of the fatal events >>>>	**Describe TYPE OF PLACE:**

Occupation and employment status>>>	Occupation or Job Title >>>>>>> Industry or kind of business>>> Employment Status >>> ___Currently employed(E) ___Self-employed(S) ___Not employed(N)

Health Care Provider name & phone>>>>	
Medical history >>>>	___Not investigated(X) ___Unknown(U) ___No past problems(N) ___Medical problems(P)
Medical informant >>>	__None(N) __Doctor(D) __Med Records(M) ___Health Provider(H) __Family(F) __Other(O)

Type of disorder	Yes	No	Unk	Specify, clarify, or comment
A) High blood pressure				
B) Heart Disease (myocardial infarction, CHF etc)				
C) Lung Disease (emphysema, asthma etc)				
D) GI Disease (ulcers, hepatitis, cirrhosis etc)				
E) Nerve System (dementia, depression, strokes etc)				
F) Substance use (alcohol, drugs, smoker etc)				
G) HIV infection				
H) Cancer or other malignancy				
I) Terminal illness				
J) Pregnant within previous 90 days				
K) Seizures (specify if due to injury, alcohol,other)				
L) Recent/old serious injury (describe)				
M) Long term effects of a previous injury (specify)				
N) Allergic reaction (specify)				
O) Other condition not in this list (specify)				

Medication history >>>	___Not investigated (X) ___Unknown (U) ___Rx meds (P) ___OTC (O) ___None(N)

Drug Names (dosage, Rx number, Rx date, pharmacy, pill count, if needed): If extra pages needed, write number here:___

AGONAL MEDICAL TREATMENT >>>	___None (N) ___CPR (R) ___Transfusion (T) ___IV fluids (F) ___Surgery (S)

Describe (a) dates and reasons for any surgery during final hospitalization or for surgery performed at any time for conditions that led to death, (b) injuries or conditions documented at hospital, (c) known or suspected complications of anesthesia or medical procedures, (d) other comments.

Case disposition:>>>>>	___**DECLINE CASE** (D) due to **OR** ___**JURISDICTION ACCEPTED** (J) for ___Topic (T) ___Locale (L) ___Autopsy(A) ___Inspection(I) ___Certification(C) ___Crem. Review(R)
Who will sign DC? >>>	
Body disposition:>>>	___Brought in for exam (E) ___Brought in for holding/claim (C) ___Released (R)
Transport agency:>>>	

# Injured, not dead:	# Companion deaths:	Companion Case Numbers:

Investigator and affiliation: Date: